A Suggested Research Agenda on Treatment-Outcome Research for Female Victims of Violence

PATRICIA A. RESICK
VA Boston Healthcare System and University of Missouri–St. Louis

Keywords: *violence against women; research agenda; treatment outcome*

I appreciate the opportunity to present my opinions on the appropriate course for the research agenda on violence against women. Briere and Jordan (this issue) have done an estimable job in reviewing the research on the psychological impact of violence on women and have concluded that, because psychological symptoms following victimization are varied, we should take a deconstructionist approach in both assessment and treatment. In the space that I have, I would like to focus my attention on suggesting an agenda for treatment-outcome research for the psychological effects of violence against women from a somewhat different perspective. First, let me set the stage for my suggestions.

Although I am an advocate of individualized case formulation, in the case of trauma, there are probably more similarities than differences among those who are having difficulty recovering. It is important to understand the relationship between and function of the varied symptoms that we observe. We know that the most likely disorder to develop in the aftermath of trauma is posttraumatic stress disorder (PTSD; Kessler, Sonnega, Bromet, & Hughes, 1995; Resick, 2001a; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Although retrospective community samples find that approximately 20% of women who have been exposed to trauma reported sufficient symptoms to be diagnosed with PTSD at some point, studies of prospective and treatment-seeking samples of female victims of interpersonal violence find very high rates of PTSD. For example, in a prospective assessment study of rape victims, symptomatic PTSD was almost universal at 1 week post-rape, and almost half of the participants still had PTSD 3 months later (Rothbaum, Foa, Riggs, & Walsh, 1992). My own prospective study with rape victims mapped

JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 19 No. 11, November 2004 1290-1295
DOI: 10.1177/0886260504271339

on to those findings exactly (Resick, 2003). Among battered women, estimates vary widely depending on the study, but PTSD ranges from 31% to 84% (Gleason, 1993; Kemp, Rawlings, & Green, 1991). In a study my colleagues and I completed recently, of 350 battered women, both shelter and nonshelter, who were assessed between 1 and 6 months after the most recent incident, 75% of the women had current PTSD (Resick, 2003). And although there are 17 core symptoms that indicate "caseness" for PTSD, rape victims and battered women with PTSD report elevated symptoms on almost every measure they are given (Kilpatrick, Resick, & Veronen, 1981; Resick, 1993; Resick, Calhoun, Atkeson, & Ellis, 1981; Resick, Nishith, & Griffin, 2003). There may be no such thing as simple PTSD that is limited only to those 17 core symptoms.

The purpose of diagnostic criteria is not to describe all possible symptoms but to identify the subset of symptoms that best identifies a group with a common disorder. Although they could be refined further, the diagnostic criteria of PTSD actually do a rather good job of identifying people with significant problems in the aftermath of trauma. Sometimes other posttrauma symptoms rise to the level of diagnosable disorders. The most common comorbid disorder is major depressive disorder (MDD), which is present in approximately half of the people who develop PTSD (Breslau, Davis, Andreski, & Peterson, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Resick, Nishith, Weaver, Astin, & Feuer, 2002). It is interesting to note that MDD rarely occurs in the absence of PTSD among samples of rape and domestic violence survivors (Resick, 2001b). Substance-use disorders are also common (Breslau et al., 1991; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). There is evidence in both cases that the depression or the substance abuse is secondary to the PTSD (Breslau, Davis, Peterson, & Schultz, 1997, 2000; Chilcoat & Breslau, 1998; Kilpatrick et al., 2000) and not exposure to trauma per se. Although every single problem that follows trauma has not been examined with regard to PTSD, the other symptoms and problems that have been examined thus far appear to be mediated by PTSD and are secondary problems. More research is needed to elucidate the relationship between symptoms and determine if there are subtypes of PTSD.

To focus in treatment, scattershot, on the range of symptoms is to ignore the function of those symptoms and the underlying problem, and it may therefore lead to different treatment plans than if the symptoms were conceptualized within one framework. For example, if a therapist diagnoses a client with anger and depression, he or she might develop a treatment plan for anger management and another for depression. However, if the therapist realizes that the anger and depression are secondary to PTSD and will remediate with the treatment of PTSD, a very different treatment plan will ensue. Although

some symptoms, such as difficulty with affect regulation, may indicate failures in appropriate development, many associated PTSD symptoms reflect maladaptive attempts to avoid the trauma memory and cope with strong affect associated with the memory (e.g., substance abuse or self-harm behaviors) or are by-products of the avoidance (e.g., depression following social withdrawal). Treatment needs to focus on processing the core traumas, not just on symptoms.

Fortunately, there is evidence that cognitive behavioral treatments are very effective for 75% to 80% of women with chronic PTSD and multiple victimization histories who complete treatment (Foa et al., 1999; Resick et al., 2002), with evidence showing decreased depression, anxiety, and guilt cognitions in addition to PTSD. In a recent publication (Resick et al., 2003), my colleagues and I examined these effective brief treatments for PTSD on a range of other symptoms using the Trauma Symptom Inventory (TSI; Briere, 1995). We divided the sample of rape victims into those with or without a history of child sexual abuse, in addition to the index rape, in an attempt to examine those who were most likely to have complex PTSD. The TSI taps into a number of the problems reported by those with complex presentations such as dissociation, impaired self-reference, sexual dysfunctions, or tension reduction behaviors. Both groups improved significantly on all subscales as a result of the PTSD treatment, and the group mean scores were within normal limits. Other studies have found that cognitive behavioral treatments are effective not only for PTSD but for a range of other symptoms (Chard, 2003; Foa et al., 1999). These data indicate that, rather than treating symptoms and problems separately, which would prolong treatment significantly, it might be possible to treat the core problem, PTSD, and then the secondary problems will abate on their own.

We need more research on the influence of effective trauma treatment on other corollary reactions. For example, we know little about the effects of PTSD treatment on interpersonal relationships. Perhaps people need couples or family counseling in addition to treatment for the trauma; however, it is possible that once the PTSD symptoms have remediated, the person will be able to relate better to others and will not need further treatment. Cloitre and her colleagues (Cloitre, Koenen, Cohen, & Han, 2002) have conducted treatment studies with adults who had been sexually abused as children in a protocol that combines affect tolerance and regulation skills and interpersonal skills training with exposure treatment. This study found that, compared to untreated controls, the treated women improved on PTSD, affect regulation, and interpersonal functioning. It would be interesting to determine if the latter measures improved even without the additional treatment components.

We also need more research on the best treatments for PTSD and other serious comorbid conditions such as substance abuse or borderline personality disorder. There have been some small studies that have focused on combined treatments for PTSD and substance dependence (Brady, Dansky, Back, Foa, & Carroll, 2001; Najavits, Weiss, Shaw, & Muenz, 1998; Triffleman, 2000). A second example is a study by Falsetti and her colleagues (Falsetti, Resnick, Davis, & Gallagher, 2001) that examined a combination treatment for PTSD and panic disorder. Although these studies have taken important steps, none of the forgoing studies included a comparison group of PTSD treatment only to determine the effect of PTSD treatment on the comorbid disorder and the incremental improvement of other components. A great deal more research is needed to determine the best combination and sequencing of treatments and the incremental benefits of adding extra component treatments to a PTSD package. I agree with Briere and Jordan that we need more treatment-outcome research on populations that have largely been ignored, such as battered women or victims of stalking, particularly those who are still in danger. How to help with symptoms from prior events while assisting with current stressors is a perplexing and complex challenge. Eventually, of course, our treatment goal will be to speed recovery from traumatic events and prevent the development of chronic symptoms.

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Patricia A. Resick, Ph.D., is the Director of the Women's Health Sciences Division of the National Center for PTSD at the VA Boston Healthcare System. She is also a Professor of Psychiatry at Boston University and Curators' Professor of Psychology at the University of Missouri—St. Louis (on leave). Dr. Resick received her Doctorate in Psychology from the University of Georgia. Dr. Resick has received grants from NIH, NIJ, and CDC to conduct research on the effects of traumatic events, particularly on women, and to develop and test therapeutic interventions for PTSD. She has published two books and over 100 journal articles and book chapters. Dr. Resick has served on the editorial boards of eight scientific journals; was on the Board of Directors of the International Society for Traumatic Stress Studies for six years including terms as Secretary and Vice-President; and has been a Board Member for the Association for the Advancement of Behavior Therapy (AABT) for two terms. She is currently President of AABT. Dr. Resick has received numerous awards for her research.